



Patient's Name: Last		First	Middle	Birthdate
Submitting Facility Patient ID (MRN)				Gender
Client/Facility Name		Address		Phone
Ordering Provider		City, State, Zip		Fax

Specimen Information		Mark as applicable			STAT <input type="checkbox"/>
Collection Date:	Time:	Source	Level	Pour off tubes, specify:	
	AM/PM	<input type="checkbox"/> Urine <input type="checkbox"/> Blood <input type="checkbox"/> Stool <input type="checkbox"/> Other (specify):	<input type="checkbox"/> Random <input type="checkbox"/> Peak <input type="checkbox"/> Trough	<input type="checkbox"/> Serum <input type="checkbox"/> Plasma, heparin <input type="checkbox"/> Plasma, EDTA <input type="checkbox"/> Plasma, other (specify):	

<input type="checkbox"/> Basic Drug of Abuse Screen, 5 drugs Amphetamines, Cannabinoids, Cocaine metabolite, Opiates & Phencyclidine <input type="checkbox"/> with ethanol
<input type="checkbox"/> Expanded Drug of Abuse Screen, 9 drugs Amphetamines, Barbiturates, Benzodiazepines, Cannabinoids, Cocaine metabolite, Methadone, Opiates, Phencyclidine & Propoxyphene <input type="checkbox"/> with ethanol
<input type="checkbox"/> Common Overdose Screen, 12 drugs Acetaminophen, Amphetamines, Barbiturates, Benzodiazepines, Cannabinoids, Cocaine metabolite, Methadone, Opiates, Phencyclidine, Propoxyphene, Salicylates & Tricyclic antidepressants <input type="checkbox"/> with volatiles
<input type="checkbox"/> Expanded Overdose Screen, >150 drugs
<input type="checkbox"/> Meconium Drug Screen, 9 drugs Amphetamines, Barbiturates, Benzodiazepines, Cannabinoids, Cocaine metabolite, Methadone, Opiates, Phencyclidine & Propoxyphene <input type="checkbox"/> confirm all positives
<input type="checkbox"/> Volatile/Alcohol Panel, Quant Ethanol, Acetone, Methanol & Isopropanol
<input type="checkbox"/> Ethanol
<input type="checkbox"/> Methanol
<input type="checkbox"/> Ethylene Glycol

<input type="checkbox"/> Caffeine	<input type="checkbox"/> Methotrexate
<input type="checkbox"/> Carbamazepine	<input type="checkbox"/> Phenobarbital
<input type="checkbox"/> Cyclosporine	<input type="checkbox"/> Phenytoin
<input type="checkbox"/> Gentamicin	<input type="checkbox"/> Sirolimus
<input type="checkbox"/> Levetiracetam	<input type="checkbox"/> Tacrolimus
<input type="checkbox"/> Lithium	<input type="checkbox"/> Tobramycin

<input type="checkbox"/> EBV Quant PCR Source: EDTA whole blood
<input type="checkbox"/> Enterovirus/Parechovirus PCR Source: CSF
<input type="checkbox"/> HSV PCR Qualitative PCR Source: circle one CSF / EDTA whole blood / skin swab
<input type="checkbox"/> Respiratory Panel PCR NP swab in UTM

CMH Processing Name	Account	QA Review (initial/date)
-------------------------------	----------------	---------------------------------